Societies Insurance

Societies Insurance
Phone: 800-616-3490
Cell: 206-755-0101
Internet: www.societiesinsurance.com
Email: info@societiesinsurance.com

OPTOMETRISTS SUPPLEMENTAL APPLICATION

Please answer all questions. Attach additional sheets if more space is needed.

SECTION I. APPLICANT INFORMATION

1. Proposed Effective Date: _____ To _____
2. Named Insured (full legal name): _____
3. DBA / Trade name(s): _____
4. Mailing Address: _____
5. City: _____ State: _____ Zip Code: _____
6. Contact Name: _____ Phone: _____
7. Email Address: _____ Website: _____
8. FEIN: _____ Year business started: _____ Years of industry experience: _____
9. Type of entity

   ☐ Individual / sole proprietor ☐ Partnership ☐ Corporation
   ☐ LLC ☐ Nonprofit ☐ Other

SECTION II. BUSINESS OPERATIONS

10. Describe your operations in detail: _____
11. Additional description: _____
12. Gross revenue - last 12 months: $ _____ Next 12 months: $ _____
13. Full-time employees: _____ Part-time employees: _____ Annual payroll: $ _____
14. Address of each location (attach a list if more than one): _____

SECTION III. PRACTICE PROFILE

15. List each provider to be insured:

Name	License Type / #	Specialty	Years in Practice

16. Annual patient / client visits: _____ Number of locations: _____
17. Are all providers licensed and credentialed where required? ☐ Yes ☐ No
18. Has any provider's license been suspended, restricted or placed on probation? ☐ Yes ☐ No

    If yes, explain: _____
19. Do you maintain written informed-consent and incident-reporting procedures? ☐ Yes ☐ No
20. Are electronic records protected by HIPAA-compliant security? ☐ Yes ☐ No

SECTION IV. OPTOMETRISTS

21. Are you certified for therapeutic drugs and glaucoma treatment? ☐ Yes ☐ No

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22. Do you perform any laser or minor surgical procedures? ☐ Yes ☐ No

    If yes, explain: _____

23. Do you fit specialty contact lenses or orthokeratology? ☐ Yes ☐ No
24. Do you operate an optical dispensary? ☐ Yes ☐ No
25. Optical frame and lens inventory value: $ _____
26. Annual patient exams: _____

SECTION V. COVERAGE REQUESTED

27. Professional liability limit (each claim / aggregate)

    ☐ $500K / $1.5M ☐ $1M / $3M ☐ $2M / $4M ☐ Other

28. General liability limits (each occurrence / aggregate)

    ☐ $500K / $1M ☐ $1M / $2M ☐ $2M / $4M ☐ Other

29. Policy form

    ☐ Claims-made ☐ Occurrence ☐ Either

30. Do you also want property / business owners coverage quoted? ☐ Yes ☐ No

SECTION VI. PRIOR INSURANCE

31. List current and prior insurance (last 3 years):

Policy Year	Insurance Company	Coverage	Limits	Premium

32. Current policy expiration date: _____

SECTION VII. LOSS HISTORY

33. Any claims, lawsuits, demands or losses in the past 5 years (insured or not)? ☐ Yes ☐ No

    If yes, explain: _____

34. Has any insurer cancelled, declined or non-renewed coverage for you in the past 3 years? ☐ Yes ☐ No

    If yes, explain: _____

35. Are you aware of any incident or circumstance that could give rise to a claim? ☐ Yes ☐ No

    If yes, explain: _____

36. List all claims in the past five (5) years (attach currently valued loss runs):

Date of Loss	Type of Loss	Description	Amount Paid	Status (O/C)

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Fraud Warnings:
Please refer to Acord 63 for state specific fraud warnings: This application cannot be considered complete until the signed ACORD 63 fraud warning statement has also been attached.

All Other States: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing materially false information may be guilty of a criminal offense and may be subject to fines and confinement in prison, and denial of insurance benefits.

WARRANTIES AND REPRESENTATIONS

In submitting this application, the undersigned warrants and represents that:

a) The information in this application and all attachments is true and complete as of the date submitted;
b) The insurer may, and is intended to, rely upon such information in determining whether to issue coverage and, if so, at what premium and upon what terms;
c) Upon any change in circumstances which bears upon the accuracy or completeness of the undersigned's representations herein prior to binding, he/she shall notify the insurer in writing and such notice shall become a part of this application;
d) The insurer may change the quoted premium and/or the terms of any coverage if, subsequent to the submission of this application, it becomes aware of any such circumstances, whether by notice from the undersigned or otherwise;
e) The undersigned authorizes the insurer and its agents to obtain information regarding the applicant's prior insurance, claims history, loss runs and, where permitted by law, motor vehicle and credit reports; and
f) The submission of this application shall not bind the insurer or its agents to the issuance of insurance coverage, nor shall it bind the undersigned to accept insurance coverage.

Applicant Name (Required)	**Applicant Signature (Required)**	**Title (Required)**	**Date (Required)**
Applicant Phone (Required)	**Applicant Email (Required)**		
Producer Name (Required)	**Producer Signature (Required)**		**Date (Required)**
Producer Phone (Required)	**Producer Email (Required)**	**State License # (Required)**	**Producer NPN (Required)**

Societies Insurance | Agency NPN 16247324
Producing Agency